BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **JUDE N. NWOSU** 5101 South Mill Avenue, #255 Tempe, AZ 85282 Registered Nurse License No. 608042, Respondent.	Case No. 2007-248

DECISION AND ORDER

The attached Stipulated Surrender of License and Order is hereby adopted by the Board of Registered Nursing, Department of Consumer Affairs, as its Decision in this matter.

This Decision shall become effective on August 18, 2008.

IT IS SO ORDERED August 18, 2008.

LaFrancene M Tate

FOR THE BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS

EDMUND G. BROWN JR., Attorney General
of the State of California
ALFREDO TERRAZAS
Senior Assistant Attorney General
ARTHUR D. TAGGART, State Bar No. 083047
Supervising Deputy Attorney General
California Department of Justice
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 324-5339
Facsimile: (916) 327-8643

Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **JUDE N. NWOSU** 5101 South Mill Avenue, #255 Tempe, AZ 85282 Registered Nurse License No. 608042, Respondent.	Case No. 2007-248 **STIPULATED SURRENDER OF LICENSE AND ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties in this proceeding that the following matters are true:

PARTIES

1. Ruth Ann Terry, M.P.H., R.N. (Complainant), is the Executive Officer of the Board of Registered Nursing. She brought this action solely in her official capacity and is represented in this matter by Edmund G. Brown Jr., Attorney General of the State of California, by Arthur D. Taggart, Supervising Deputy Attorney General.

2. Respondent Jude N. Nwosu is representing himself in this proceeding and has chosen not to exercise his right to be represented by counsel.

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3. On or about October 15, 2002, the Board of Registered Nursing issued Registered Nurse License No. 608042 to Jude N. Nwosu (Respondent). Said license will expire on February 29, 2008, unless renewed.

JURISDICTION

4. Accusation No. 2007-248 was filed before the Board of Registered Nursing (Board), Department of Consumer Affairs, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on April 3, 2007. Respondent timely filed his Notice of Defense contesting the Accusation. A copy of Accusation No. 2007-248 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, discussed with counsel, and fully understands the charges and allegations in Accusation No. 2007-248. Respondent also has carefully read and fully understands the effects of this Stipulated Surrender of License and Order.

6. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to be represented by counsel, at his own expense; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

7. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

8. Respondent admits the truth of each and every charge and allegation in Accusation No. 2007-248, agrees that cause exists for discipline, and hereby surrenders his Registered Nurse License No. 608042 for the Board's formal acceptance.

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9. Respondent understands that by signing this stipulation he enables the Board to issue an order accepting the surrender of his Registered Nurse License without further process.

CONTINGENCY

10. This stipulation shall be subject to approval by the Board of Registered Nursing. Respondent understands and agrees that counsel for Complainant and the staff of the Board of Registered Nursing may communicate directly with the Board regarding this stipulation and surrender, without notice to or participation by Respondent. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Surrender and Disciplinary Order shall be of no force or effect, except for this paragraph it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

OTHER MATTERS

11. The parties understand and agree that facsimile copies of this Stipulated Surrender of License and Order, including facsimile signatures thereto, shall have the same force and effect as the originals.

12. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Order:

ORDER

IT IS HEREBY ORDERED that Registered Nurse License No. 608042, issued to Respondent Jude Nwosu, is surrendered and accepted by the Board of Registered Nursing.

13. The surrender of Respondent's Registered Nurse License and the acceptance of the surrendered license by the Board shall constitute the imposition of discipline against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Board.

14. Respondent shall lose all rights and privileges as a Registered Nurse in California as of the effective date of the Board's Decision and Order.

15. Respondent shall cause to be delivered to the Board both his pocket license and wall certificate on or before the effective date of the Decision and Order.

16. Respondent fully understands and agrees that if he ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 2007-248 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

17. Upon reinstatement of the license, Respondent shall pay to the Board costs associated with its investigation and enforcement pursuant to Business and Professions Code section 125.3 in the amount of Five Hundred Eleven Dollars and Seventy-Five Cents ($511.75). Respondent shall be permitted to pay these costs in a payment plan approved by the Board.

18. Respondent shall not apply for licensure or petition for reinstatement for two (2) years from the effective date of the Board of Registered Nursing's Decision and Order.

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ACCEPTANCE

I understand that I have the right to retain private counsel at my own expense. I have chosen to represent myself in this proceeding. I have carefully read the above Stipulated Surrender of License and Order I understand the stipulation and the effect it will have on my Registered Nurse License. I enter into this Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Board of Registered Nursing.

DATED: 3-27-08.

JUDE N. NWOSU
Respondent

ENDORSEMENT

The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted for consideration by the Board of Registered Nursing of the Department of Consumer Affairs.

DATED: May 16, 2008

EDMUND G. BROWN JR., Attorney General
of the State of California

ARTHUR D. TAGGART
Supervising Deputy Attorney General

Attorneys for Complainant

Exhibit A

Accusation No. 2007-248

EDMUND G. BROWN JR., Attorney General
of the State of California
ALFREDO TERRAZAS
Senior Assistant Attorney General
ARTHUR D. TAGGART, State Bar No. 83047
Supervising Deputy Attorney General
California Department of Justice
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 324-5339
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Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: JUDE N. NWOSU 5101 South Mill Avenue, #255 Tempe, AZ 85282 Registered Nurse License No. 608042 Respondent.	Case No. 2007-248 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H., R.N. ("Complainant") brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

2. On or about October 15, 2002, the Board issued Registered Nurse License Number 608042 to Jude N. Nwosu ("Respondent"). The registered nurse license was in full force and effect at all times relevant to the charges brought herein and will expire on February 29, 2008, unless renewed.

STATUTORY PROVISIONS

3. Section 2750 of the Business and Professions Code ("Code") provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

4. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811(b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

5. Section 2761 of the Code states in pertinent part:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (4) Denial of licensure, revocation, suspension, restriction, or any other disciplinary action against a health care professional license or certificate by another state or territory of the United States, by any other government agency, or by another California health care professional licensing board. A certified copy of the decision or judgment shall be conclusive evidence of that action.

COST RECOVERY

6. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

CAUSE FOR DISCIPLINE

(Out-of-State Discipline)

7. Respondent's registered nurse license is subject to disciplinary action under Code section 2761(a)(4) on the grounds of unprofessional conduct, in that on or about July 16, 2004, pursuant to the Consent for Entry of Voluntary Surrender, Order No. 0205036, *In*

the Matter of Professional Nurse License No. RN114528 Issued to: Jude Nnamentelum Nwosu (attached hereto as **Exhibit A**), the Arizona State Board of Nursing accepted the voluntary surrender of Respondent's Arizona Professional Nurse License, No. 114528. The basis of said discipline is as follows:

a. While working for MD Home Health, Inc. in Phoenix, Arizona, on or about October 7, 2002 and October 8, 2002, Respondent locked himself in a room with a seventeen year old female patient in her home. Additionally, Respondent slept on the shift.

b. While working as a nurse in Phoenix, Arizona, on or about September 13, 2003, Respondent neglected to obtain a medical evaluation on a 45 year old developmentally disabled patient who was in pain, had a swollen left knee and an elevated fever. It was subsequently discovered the patient had a fractured left femur.

c. During the period November 4, 2003 and November 19, 2003, during nursing refresher courses at Gateway Community College in Arizona, Respondent failed to demonstrate a fundamental familiarity with the basic requirements of the nursing profession, including a lack of knowledge of basic nursing skills, poor technique and poor attitude. On or about November 20, 2003, Respondent failed the course.

d. While working for Maxim Healthcare on or about May 24, 2004, Respondent inserted a catheter into a 55 year old developmentally disabled adult's penis, inflated the catheter balloon and then pulled the catheter out while the balloon was still inflated, causing the patient severe pain and the patient's penis to bleed.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 608042, issued to Jude N. Nwosu;

2. Ordering Jude N. Nwosu to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Code section 125.3; and

3. Taking such other and further action as deemed necessary and proper.

DATED: 3/26/07

RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

03579110-SA2006101938
Nwosu.acc.wpd
BC [2/9/2007]

EXHIBIT A

ARIZONA STATE BOARD OF NURSING
1651 East Morten Avenue, Suite 210
Phoenix, Arizona 85020-4613
602-889-5150

IN THE MATTER OF PROFESSIONAL NURSE LICENSE NO. RN114528 and NURSING ASSISTANT CERTIFICATE NO. CNA999989630 ISSUED TO: JUDE NNAMENTELUM NWOSU, Respondent.	**CONSENT FOR ENTRY OF VOLUNTARY SURRENDER ORDER NO. 0205036**

The Arizona State Board of Nursing ("Board") received several complaints charging Jude Nnamentelum Nwosu ("Respondent") with violations of the Nurse Practice Act. In the interest of a prompt and speedy settlement of the above-captioned matter, consistent with the public interest, statutory requirements, and the responsibilities of the Board, and pursuant to A.R.S. §32-1663 (D)(5), Respondent voluntarily surrenders his license for a minimum of three years.

Based on the evidence before it, the Board makes the following Findings of Fact, Conclusions of Law:

FINDINGS OF FACT

1. The Arizona State Board of Nursing ("Board") has the authority to regulate and control the practice of nursing in the State of Arizona, pursuant to A.R.S. §§32-1606, 32-1663, and 32-1664. The Board also has the authority to impose disciplinary sanctions against the holders of nursing licenses for violations of the Nurse Practice Act, A.R.S. §§32-1601 to -1667.

2. Jude Nnamentelum Nwosu ("Respondent") holds Board-issued professional nurse license No. RN114528, which is valid through June 30, 2005.

3. From on or about July 23, 2002, to on or about October 11, 2002, Respondent was employed by MD Home Health, Inc. in Phoenix, Arizona.

4. On or about October 7, 2002, and on or about October 8, 2002, Respondent provided nursing care to A.S., a 17 year old female, in the patient's home from 7:00 a.m. to 7:00 p.m. each day. On or about October 8, 2002, patient A.S.'s mother complained to MD Home Health staff that Respondent locked the door to A.S.'s room at different intervals throughout his shift on both days. Respondent admitted to sleeping while on duty for a short interval on October 7, 2002.

5. On or about October 11, 2002, Respondent's employment from MD Hone Health was terminated for unprofessional conduct, and related to his care of A.S.

6. On or about June 2, 2002, Respondent's employment was terminated from CareStaf, a nursing registry, after the registry received a complaint against Respondent of alleged inappropriate behavior while working on or about May 31, 2002, at Mesa Christian Care Center.

7. From on or about February 7, 2002, to on or about May 14, 2002, Respondent was employed by Highland Manor Nursing Home in Phoenix, Arizona.

8. As documented in complaint #OLTC010121075, Arizona Department of Health Services substantiated that Respondent failed to follow professional conduct by allowing a nursing assistant to perform a complex wound dressing change for resident R.V. on or about May 4th and May 5th, 2002. Respondent asserts that the nursing assistant performed the dressing change without Respondent's knowledge or permission.

9. On or about May 14, 2002, Respondent's employment with Highland Manor Nursing Home was terminated as a result of Respondent's alleged failure to document and/or administer medications, and initiate a STAT order. Respondent told Board staff that he was not terminated, but that he resigned due to poor staffing and unsafe patient condition.

10. On or about September 13, 2003, Respondent failed to obtain a medical evaluation on a 45 year old developmentally disabled patient who had a painful and swollen left knee

and an elevated temperature. Respondent asserts that he applied ice and administered pain medication, but failed to make arrangements for the medical evaluation. Respondent failed to document his action in the Nurses' Notes on September 13, 2003. The oncoming evening shift nurse assessed J.P.'s left knee, contacted the primary care provider and sent J.P. to the emergency room for an x-ray where it was determined that J.P. had a fractured left femur. Following an AHCCCS' investigation of this situation, the allegation of neglect against Respondent was substantiated.

11. On or about November 4, 2003, while attending NCE275, a RN Refresher Course at Gateway Community College, Respondent met with his instructor and received a clinical warning regarding his performance. In the Refresher course the student is expected to have fundamental familiarity with the nature of clinical practice, clinical communication skills, and knowledge of fundamental patient care skills in a medical-surgical environment. The clinical warning identified that Respondent: a) demonstrated gaps in knowledge base and performance in the emergency room setting; b) lacked in certain basic care skills and medication administration skills; and c) received complaints from staff in his clinical site relating to his inattentiveness, poor technique in IV therapy skills and sterile fields, and having a defensive attitude. Respondent's clinical was moved from the emergency room to Unit 3A, a medical-surgical unit, where Respondent was able to be evaluated more closely and able to provide return demonstration of skills. According to the documentation, Respondent denied having a defensive attitude.

12. On or about November 19, 2003, the Instructor for NCE275 received a call from Respondent's clinical site requesting that he not return to unit 3A for the following reasons: a) Respondent places excessive demands on staff time due to his lack of fundamental knowledge of the nursing process; b) Respondent is considered unsafe in practices related to assessment of patients, communication with patients, reporting important information to the preceptor, medication

administration via injection, and use of IV equipment; c) Respondent's skill level is considered below that of a newly graduated RN, and some have placed it below the level of a new student; d) Respondent lacks initiative; e) Respondent prioritizes poorly; and f) Respondent takes direction poorly.

13. On or about November 20, 2003, the Board received information from Gateway Community College that Respondent was withdrawn from NCE275, because Respondent was not passing the course and could not correct deficiencies in the remaining six clinical days. The course instructor recommended that Respondent be permitted to repeat the course and take Principles of IV Therapy and Physical Assessment concurrently. The instructor also stated that Respondent should not be allowed unsupervised practice as a professional nurse at this time.

14. On or about June 7, 2004, the Board received a complaint against Respondent from Adult Protective Services alleging his patient abuse. It was reported that on or about May 24, 2004, Respondent caused severe pain when inserting a foley catheter into the penis of a 55 year old developmentally disabled adult while employed by Maxim Healthcare. Respondent filed a written statement with his employer explaining what occurred. Respondent said he removed the old catheter from S.F. without a problem and inserted the new catheter. He explained that as he was starting to inject the sterile water into the balloon to hold the catheter in place, S.F. pulled the catheter out. Respondent reinserted the catheter and inflated the balloon, however, this time S.F. pulled out the catheter with the balloon inflated causing his penis to bleed. Respondent said that he deflated the balloon, washed his hands, and reinserted the catheter with the help of a caregiver named Marilyn who restrained S.F.'s hands. Respondent then cleaned up S.F., put on a new diaper and medicated him for pain before leaving.

15. On or about June 23, 2004, the Guardian for S.F. told Board staff that she observed blood in S.F.'s catheter tubing and that the catheter collection bag was ¾ full of bloody fluid. S.F. could not feed himself, grip or hold a pencil or object, and had limited arm movement.

CONCLUSIONS OF LAW

Pursuant to A.R.S. §32-1606, 32-1663, and 32-1664, the Board has subject matter and personal jurisdiction in this matter.

1. The conduct and circumstances described in the Findings of Fact constitute violations of A.R.S. § 32-1663(D), as defined in A.R.S. §32-1601(16)(d) and (j), and A.A.C. R4-19-403(1), (2), (5), (6), (10) and (25).

2. The conduct and circumstances described in paragraphs 3 through 15 of the Findings of Fact constitute unprofessional conduct pursuant to A.R.S. §32-1601(16)(d), (any conduct or practice that is or might be harmful or dangerous to the health of a patient or the public), and is grounds for disciplinary action pursuant to A.R.S. §32-1663 and §32-1664.

3. The conduct and circumstances described in paragraphs 3 through 15 of the Findings of Fact constitute unprofessional conduct pursuant to A.R.S. §32-1601(16)(d), (any conduct or practice that is or might be harmful or dangerous to the health of a patient or the public); specifically, Respondent's actions and inactions described in paragraphs 3 through 15 fell below the stand of care and were or may have been harmful or dangerous to his patients, and are grounds for disciplinary action pursuant to A.R.S. §32-1663 and §32-1664.

4. The conduct and circumstances described in paragraphs 3 through 15 of the Findings of Fact constitute unprofessional conduct pursuant to A.R.S. §32-1601(16)(e), (being mentally incompetent or physically unsafe to a degree that is or might be harmful or dangerous to the health of a patient or the public), specifically, that Respondent has failed to demonstrate that he has

the knowledge and/or training to practice professional nursing safely and without endangering the public, and is grounds for disciplinary action pursuant to A.R.S. §32-1663 and §32-1664.

5. The conduct and circumstances described in paragraphs 3 through 15 of the Findings of Fact constitute unprofessional conduct pursuant to A.R.S. §32-1601(16)(j), (violating a rule that is adopted by the board pursuant to this chapter, specifically, A.A.C. R4-19-403(1), (a pattern of failure to maintain minimum standards of acceptable and prevailing nursing practice), and is grounds for disciplinary action pursuant to A.R.S. §32-1663 and §32-1664.

6. The conduct and circumstances described in paragraphs 3 through 15 of the Findings of Fact constitute unprofessional conduct pursuant to A.R.S. §32-1601(16)(j), (violating a rule that is adopted by the board pursuant to this chapter, specifically, A.A.C. R4-19-403(2), (intentionally or negligently causing physical or emotional injury), and is grounds for disciplinary action pursuant to A.R.S. §32-1663 and §32-1664.

7. The conduct and circumstances described in paragraphs 3 through 15 of the Findings of Fact constitute unprofessional conduct pursuant to A.R.S. §32-1601(16)(j), (violating a rule that is adopted by the board pursuant to this chapter, specifically, A.A.C. R4-19-403(5), (failing to maintain for each patient a record which accurately reflects the nursing care and treatment provided to a patient), and is grounds for disciplinary action pursuant to A.R.S. §32-1663 and §32-1664.

8. The conduct and circumstances described in paragraphs 3 through 15 of the Findings of Fact constitute unprofessional conduct pursuant to A.R.S. §32-1601(16)(j), (violating a rule that is adopted by the board pursuant to this chapter, specifically, A.A.C. R4-19-403(6), (failing to take appropriate action to safeguard a patient's welfare or to follow policies and procedures of the nurse's employer designed to safeguard the patient), and is grounds for disciplinary action pursuant to A.R.S. §32-1663 and §32-1664.

9. The conduct and circumstances described in paragraphs 3 through 15 of the Findings of Fact constitute unprofessional conduct pursuant to A.R.S. §32-1601(16)(j), (violating a rule that is adopted by the board pursuant to this chapter, specifically, A.A.C. R4-19-403(9), (assuming patient care responsibilities for which the nurse lacks the education to perform or for which the nurse has failed to maintain nursing competence), and is grounds for disciplinary action pursuant to A.R.S. §32-1663 and §32-1664.\

10. The conduct and circumstances described in paragraphs 3 through 15 of the Findings of Fact constitute unprofessional conduct pursuant to A.R.S. §32-1601(16)(j), (violating a rule that is adopted by the board pursuant to this chapter, specifically, A.A.C. R4-19-403(25), (practicing in any other manner which gives the Board reasonable cause to believe that the health of a patient or the public may be harmed, and is grounds for disciplinary action pursuant to A.R.S. §32-1663 and §32-1664.

The conduct and circumstances described in the Findings of Fact constitute sufficient cause pursuant to A.R.S. §§32-1663(D)(5) 32-1664(N) to take disciplinary action against Respondent's license to practice as a professional nurse in the State of Arizona.

Respondent acknowledges that the Board possesses a preponderance of the evidence to establish that his actions violated the Nurse Practice Act.

Respondent understands that he has an opportunity to request a hearing and declines to do so. Respondent agrees to issuance of the attached Order and waives all rights to a hearing, rehearing, appeal, or judicial review relating to this Order.

Respondent understands that all investigative materials prepared or received by the Board concerning these violations and all notices and pleadings relating thereto may be retained in the Board's file concerning this matter.

Respondent understands that the admissions in the Findings of Fact are conclusive evidence of a violation of the Nurse Practice Act and may be used for purposes of determining sanctions in any future disciplinary matter.

Respondent understands the right to consult legal counsel prior to entering into the Consent Agreement and such consultation has either been obtained or is waived.

Respondent understands that this voluntary surrender is effective upon its acceptance by the Executive Director or the Board and by Respondent as evidenced by the respective signatures thereto. The effective date of this Order is the date the Voluntary Surrender is signed by the Executive Director or the Board and by Respondent. If the Voluntary Surrender is signed on a different date, the later date is the effective date.

Respondent understands that Voluntary Surrender constitutes disciplinary action. Respondent also understands that he may not reapply for reinstatement of his professional (RN) nurse license during the period of Voluntary Surrender.

If Respondent meets all the Board's application requirements, he may apply for practical (LPN) licensure, upon completion of an application and successful passing of NCLEX. The Board shall not consider the voluntary surrender of his professional nurse license as a sole basis to bar his licensure as a practical nurse. However, the Board may consider conditional licensure requirements at the time of application.

Respondent agrees that he may apply for reinstatement of his professional (RN) nurse license after the period of voluntary surrender under the following conditions, and must comply with current law at the time of their application for reinstatement:

The application for reinstatement must be in writing and shall contain therein or have attached thereto substantial evidence that the basis for the voluntary surrender has been removed and

that the reinstatement of the license does not constitute a threat to the public's health, safety and welfare. The Board may require physical, psychological, or psychiatric evaluations, reports and affidavits regarding the Respondent as it deems necessary. These conditions shall be met before the application for reinstatement is considered.

Jude Nwosu

Respondent

Date: 7-16-04

SEAL

ARIZONA STATE BOARD OF NURSING

Joey Ridenour

Joey Ridenour, R.N., M.N.
Executive Director

Dated: 7/16/04

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ORDER

Pursuant to A.R.S. §32-1663 (D)(5) the Board hereby accepts the Voluntary Surrender of professional nurse license number RN114528 issued to Jude Nnamentelum Nwosu. This Order of Voluntary Surrender hereby entered shall be filed with the Board and shall be made public upon the effective date of this Consent Agreement. Respondent shall not practice in Arizona under the privilege of a multistate license.

IT IS FURTHER ORDERED that Respondent may apply for reinstatement of said license after a period of three years.

ARIZONA STATE BOARD OF NURSING

SEAL

Joey Ridenour, R.N., M.N.
Executive Director

Dated: 7/16/04

COPY mailed this 16th day of July, 2004, by First Class Mail to:
Teressa M. Sanzio, P.C.
428 E. Thunderbird Rd., #238
Phoenix, AZ 85022

COPY mailed this 16th day of July, 2004, by First Class Mail to:
Jude Nwosu
5101 S. Mill Ave Apt 225
Tempe AZ 85282

By: